DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/31/2013 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G442	(X2) MULT A. BUILDII B. WING		NSTRUCTION 00	(X3) DATE (COMPL 11/08/	ETED	
NAME OF P	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE ING LN			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	J	IEFFER	RSONVILLE, IN 47130			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION				(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION	
TAG W000000	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE	
VV000000								
	This visit was fo	or a fundamental	W000	000				
		nd state licensure survey.						
		,						
	Dates of Survey	: October 29, 30, 31,						
	November 1 and							
		•						
	Facility Number	r: 000956						
	Provider Numbe							
	AIMS Number:	100244760						
	Surveyor: Dotty	y Walton, QIDP.						
	The following d	eficiencies reflect state						
	findings in acco	rdance with 460 IAC 9.						
	Quality Review	completed 11/18/13 by						
	Ruth Shackelfor	rd, QIDP.						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

M8CI11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G442	B. WIN	G		11/08/	2013
NAME OF P	ROVIDER OR SUPPLIER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					/ING LN		
RES CAF	RE COMMUNITY AL	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
TAG W000149	483.420(d)(1) STAFF TREATMITHE facility must of written policies are mistreatment, neg Based on record 6 of 11 facility in reportable incide to peer sexual and reviewed, affecting (#1, #2, #3, and #clients, (#5, #6, #failed to implement procedures which free of neglect/abinvestigate incident neglect and client failed to take cornon further episod sleeping on the jeep Findings include Review of the fact reports to the But Disabilities Serve 10/29/13 at 2:15 PM and on 10/31 reports indicated of client to client neglect:	ents (alleged neglect/peer d physical aggression) ng 4 of 4 sampled clients #4) and 4 additional #7 and #8), the facility ent policies and h ensured all clients were buse, failed to thoroughly ents of staff to client at to client abuse and rective action to ensure les of neglect (staff ob).	Wo	TAG 00149	W149: The facility must deve and implement written policies and procedures that prohibit mistreatment, neglect or abuse the client. Corrective Action: (Specific): Quality Assurance be in-serviced on the completion of thorough investigations in regards to client neglect and client to client abuse. Quality Assurance will be in-serviced of the completion of investigation for all allegations of client to client abuse and the implementation corrective measures to preven reoccurrence. How others we be identified: (Systemic): The Residential Manager will make random visits to the home duri all shifts at least three times weekly to ensure that staff is not sleeping on the job and the results of those visits will be set to the Program Manager finds any staff asleep while on duty, that staff member will be sent home immediately pending QA investigation and the residential manager will notify the program manager and the executive director of the incident. The Program Manager will review incident reports and	lop e of will on seent of t mill eng	12/08/2013
	job were confirm Quality Assurance	ned by the agency's ce Department:			investigations weekly with QA ensure that all allegations have		

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Event ID: M8CI11

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If continuation sheet

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED
		15G442	B. WI	NG		11/08/2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
					/ING LN	
RES CAF	RE COMMUNITY AL	_TERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130	
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	On 9/15/12 at 12 found staff #10 s reported the incident was substantiated. The BDDS report of Compart of the prevent future documentation of supervisory staff offered for review BDDS report of 6/28/13 at 11:30 staff (staff #9) which supervising client report indicated the was substantiated bdd by the BDDS report data clients at the fact sleeping on the jup PM. Quality Ass the allegation and 10/31/13.	2:00 AM clients #1 and #5 cleeping at the facility and dent to their manager. It of 9/15/12 indicated the ordinator) and the DSGL dervised Group Living dom stops at the facility occurrences. No f the observations by Swas in the materials w. 6/28/13 indicated on AM clients reported a as sleeping while ats. The 7/5/13 follow-up this allegation of sleeping			been thoroughly investigated. Measures to be put in place: Quality Assurance will be in-serviced on the completion thorough investigations in regato client neglect and client to client abuse. Quality Assurant will be in-serviced on the completion of investigations for allegations of client to client abuse and the implementation corrective measures to prevent reoccurrence. Monitoring of Corrective Action: The Residential Manager will make random visits to the home durnall shifts at least three times weekly to ensure that staff is results of those visits will be set to the Program Manager each week for review. If the Residential Manager finds any staff asleep while on duty, that staff member will be sent hom immediately pending QA investigation and the residentimanager will notify the program manager and the executive director of the incident. The Program Manager will review incident reports and investigations weekly with QA ensure that all allegations have been thoroughly investigated. Completion date 12/08/13	of ards ce or all n of of ot e ing not ent f t t e al m
	On 8/27/13 at 2:0	05 PM, a coworker put				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURV		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		15G442	B. WIN	G		11/08/2013	3
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
				402 EW			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E	MPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		client #1's shirt at break.					
	Staff redirected him and he touched her						
	_	ner shirt (outside). An					
	_	vas forwarded to the					
	I	shop supervisory staff.					
		idence an investigation of					
		nat corrective measures					
	_	event future occurrences					
		review of facility's					
	investigations.						
	On 1/14/13 client #7 was at workshop						
	sitting at a table	working and was shoved					
	from the back by	a male peer into her					
	worktable. Clien	t #7's eyeglasses were					
	broken and her e	yeglasses cut her					
	eyebrow and she	sustained a cut across					
	the side of her he	ead.					
	The incident rep	ort review indicated no					
	evidence someon	ne had investigated the					
	incident to see w	hat precipitated the					
	aggression, or w	hat corrective measures					
		ented to prevent future					
	occurrences.						
	Staff failure to p	revent elopement:					
	_	M Client #4 eloped by					
		om the facility and going					
	"	od yard sale without staff					
	_	ff #3 (who was working					
	I ~	ght clients) knew client					
		to the yard sale. Staff #3					
		and they returned client					
	#4 to the facility	-					
	TT TO THE TACIFITY	•					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G442			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/08/2013
	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN	402 EW	ADDRESS, CITY, STATE, ZIP CODE /ING LN RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	10/30/13 at 9:30 working alone and could get client #4. Sta #4 was because desire to go to the clients in the fact Staff #3 was aloone was availabent the community. The "Abuse/Neg and Procedure" 0/7/02/2012 cont Operational Polimas reviewed on PM. The review prohibited negled definitions were "AbusePhysical Definition: 1. The act or fact could result in principal polimition: 1. The act or fact could result in principal polimition: 1. The definition of follows: "C AbuseSexual Definition:	icy and Procedure Manual in October 29, 2013 at 2:30 indicated the agency ect and abuse of clients. It is as follows: all illure to act, that results or hysical injury to an all injury inflicted by or persons. If sexual abuse was as			

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		(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15G442	B. WINC			11/08/	/2013
NAME OF I	PROVIDER OR SUPPLIE	ED.		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	FROVIDER OR SUFFEII	SK.		402 EW	/ING LN		
RES CAI	RE COMMUNITY A	ALTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
		emotional injury to an					
	individual.						
		nsulting or profane					
	" "	stures directed toward an					
		subject him or her to					
	humiliation or	_					
	3. A non-conse	nsual act of a sexual nature					
	involving an in	dividual. The act may be					
	used for sexual	gratification of the					
	perpetrator or a	third party.					
	4. Anyone who allows or encourages						
	forced sexual activity."						
	E. NeglectEm	notional/Physical					
	Definition:	,					
		ovide goods and/or					
		ary to the individual to					
	avoid physical	_					
	1	ovide the support					
	1	individual's psychological					
	and social well						
		eet the basic needs such as					
		lothing and to provide a					
	safe environme	nt."					
	Imaident Man	acomout and Investigation					
		agement and Investigation					
		June, 2012 reviewed on					
	11/1/13 at 12:30 PM indicated staff						
	1 ~	estigate incidents were to					
	conduct thorough investigations.						
		o be collected and the					
	incident report	reviewed. The victim and					
	all witness of e	vents prior to, during and					
	after the incide	nt were to be interviewed					

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED
ANDILAN	15G442	A. BUILDING	00	11/08/2013
	100772	B. WING	DDDDGG GYMY GM :	11/00/2010
NAME OF P	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE /ING LN	
RES CAF	RE COMMUNITY ALTERNATIVES SE IN		RSONVILLE, IN 47130	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	and written statements were to be			
	obtained. All evidence was to be			
	organized and integrated to determine if			
	their was a breach in agency policy.			
	Conclusions were to be drawn based on			
	the evidence collected to determine if the			
	allegation could be supported or not. An			
	investigative report is to be formulated to			
	convey the results of the investigation.			
	The report should convey what happened:			
	incidents and chronology, why it			
	happened (causal factors), and "what can			
	be done to prevent recurrence."			
	•			
	Interview with the Administrator on			
	11/1/2013 at 12:20 PM indicated it was			
	the policy of the agency to report,			
	investigate and implement corrective			
	actions regarding incidents of clients'			
	neglect and abuse.			
	9-3-2(a)			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		15G442	B. WIN			11/08/	2013
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				VING LN		
RES CAF	RE COMMUNITY AI	TERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000154	483.420(d)(3)	ENT OF CLIENTS					
		nave evidence that all					
	alleged violations						
	investigated.	are morouginy					
	Based on record review and interview, the		W0	00154	W154: The facility must have	;	12/08/2013
	facility failed to	ensure for 2 of 4 sampled			evidence that all alleged		
	clients (#1 and #	4) and 1 additional client,			violations are thoroughly investigated. Corrective Action	··	
	(#7), instances of	f client to client physical			(Specific): Quality Assurance		
	abuse and staff to client neglect (failure to prevent elopement) were thoroughly investigated.				be in-serviced on the completi		
					of thorough investigations in		
					regards to client neglect and		
					client to client abuse. Quality		
	Findings include:				Assurance will be in-serviced the completion of investigation		
	i manigs merade	•			for all allegations of client to client		
	Review of the fa	cility's investigations and			abuse and the implementation		
		reau of Developmental			corrective measures to prever		
	•	•			reoccurrence. How others v		
		ices/BDDS was done on			be identified: (Systemic): The Residential Manager will make		
		PM, 10/30/13 at 12:00			random visits to the home dur		
		1/13 at 2:10 PM. The			all shifts at least three times	9	
	•	the following incidents			weekly to ensure that staff is r	ot	
		t abuse and staff to client			sleeping on the job. The Progr	ram	
	neglect:				Manager will review incident	sleb e	
					reports and investigations week with QA to ensure that all	zniy	
	Two reports of c	lient to client aggression			allegations have been thorough	ıhly	
	at the workshops	clients attended were			investigated. The Program		
	reviewed:				Manager will review incident		
					reports and investigations wee	ekly	
	On 8/27/13 at 2:0	05 PM, a coworker put			with QA to ensure that all allegations of client to client		
		client #1's shirt at break.			abuse have been reported and	d	
		nim and he touched her			are thoroughly investigated an		
		ner shirt (outside). An			that corrective measures are		
	_	as forwarded to the			implemented and monitored for		
	•	shop supervisory staff.			effectivenessMeasures to be p		
		idence an investigation of			in place: Quality Assurance wi be in-serviced on the completi		
	There was no ev	idence an investigation of	1		De ui-serviced ou me complem	011	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED	
		15G442	B. WIN			11/08/2013	
(F. 0F. P				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			402 EW	/ING LN		
	RE COMMUNITY AI	TERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION	1
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE	
		been conducted to ensure			of thorough investigations in regards to client neglect and		
		ires were taken to protect			client to client abuse. Quality		
	client #1 from further violation during the				Assurance will be in-serviced of	on	
	review of the facility's investigations.				the completion of investigation	s	
					for all allegations of client to cl		
	On 1/14/13 client #7 was at workshop				abuse and the implementation		
	sitting at a table	working and was shoved			corrective measures to preven reoccurrence. Monitoring of		
	from the back by	a male peer into her			Corrective Action: The		
		t #7's eyeglasses were			Residential Manager will make		
		yeglasses cut her			random visits to the home duri	ng	
		sustained a cut across			all shifts at least three times		
	the side of her head. The incident report review indicated no				weekly to ensure that staff is n		
					sleeping on the job. The Progr Manager will review incident	alli	
	_	ne had investigated the			reports and investigations wee	kly	
		•			with QA to ensure that all		
		that precipitated the		allegations have been thoroughly		hly	
		hat corrective measures			investigated. The Program		
	1	ented to prevent future			Manager will review incident reports and investigations wee	kly	
	occurrences.				with QA to ensure that all	Niy	
	G, 60 C 1	. 1			allegations of client to client		
	Staff failure to p	revent elopement:			abuse have been reported and		
					are thoroughly investigated an that corrective measures are	a	
		I Client #4 eloped by			implemented and monitored for	r	
		om the facility and going			effectiveness Completion date		
		d yard sale without staff			12/08/13		
	knowledge. Staf	ff #3 (who was working					
	alone with the ei	ght clients) knew client					
	#4 wanted to go	to the yard sale, so she					
	knew where she	had gone when found to					
	be missing from	the facility. Staff #3					
	_	and they returned client					
	#4 to the facility						
		erview with staff #1 on					
		AM, staff #3 was					
	working alone a	nd could not leave the					

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY COMPLETED
12.212.11(15G442	A. BUILDING		11/08/2013
		B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER		/ING LN	
RES CAF	RE COMMUNITY ALTERNATIVES SE IN		RSONVILLE, IN 47130	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
ing	facility to get client #4. Staff #3 knew	1110		BATE
	where client #4 was because she had			
	expressed a desire to go to the yard sale,			
	but other clients in the facility did not			
	want to go. Staff #3 was alone at the			
	facility so no one was available to			
	supervise client #4 in the community.			
	No investigation of the incident of client			
	#4's elopement or how it could have been			
	avoided was done. There was no			
	information regarding the lack of staff at			
	the time of the elopement.			
	Interview with Quality Assurance staff #1			
	on 10/30/13 at 2:30 PM indicated there			
	was no documented evidence the above			
	incidents had been investigated.			
	9-3-2(a)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		15G442	B. WIN			11/08/	2013
NAME OF B	AD CHARLED OD CHARLIED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			402 EW	/ING LN		
		TERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W000157	If the alleged viola corrective action in		Wo	00157			12/09/2012
		review and interview, for	WU	00157	W157: If the alleged violation		12/08/2013
	_	lients (#1, #2, #3, and #4)			verified, appropriate corrective action must be taken.Corrective		
		clients, (#5, #6, #7 and			Action: Corrective Action:		
	#8), the facility f	ailed to implement			(Specific): Quality Assurance	will	
	corrective measu	res (administrative			be in-serviced on the completion	on	
	supervision) to e	nsure further episodes of			of thorough investigations in		
	neglect (staff sle	eping on the job).			regards to client neglect and client to client abuse. Quality		
					Assurance will be in-serviced of	nn.	
	Findings include	:			the completion of investigations for all allegations of client to client		
	Review of the fa	cility's investigations and			abuse and the implementation		
		reau of Developmental			corrective measures to preven		
	•	ices/BDDS was done on			reoccurrence. How others w be identified: (Systemic): The	/III	
		PM, 10/30/13 at 12:00			Residential Manager will make	1	
		/13 at 2:10 PM. The			random visits to the home duri		
					all shifts at least three times		
	_	the following allegations			weekly to ensure that staff is n	ot	
	of staff to client	neglect:			sleeping on the job and the	4	
					results of those visits will be set to the Program Manager each	गार	
		of staff sleeping on the			week for review. If the		
		ned by the agency's			Residential Manager finds any		
	Quality Assurance	ce Department:			staff asleep while on duty, that		
					staff member will be sent home	е	
	On 9/15/12 at 12	:00 AM clients #1 and #5			immediately pending QA	-1	
	found staff #10 s	leeping at the facility and			investigation and the residential manager will notify the program		
		dent to their manager.			manager and the executive	••	
	-	investigated and			director of the incident. The		
	substantiated.	<i>5</i>			Program Manager will review		
		et of 9/15/12 indicated the			incident reports and		
	_	ordinator) and the DSGL			investigations weekly with QA		
	` •	ervised Group Living)			ensure that all allegations have been thoroughly investigated.	5	
	` .	1 0,			Measures to be put in place:		
	would make rand	lom stops at the facility					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MI	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL		
		15G442	B. WIN	G		11/08/	2013	
NAME OF B	DOLUDED OD GLIDDLIED		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER			402 EW	/ING LN			
		LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE	
	to prevent future	occurrences. No			Quality Assurance will be in-serviced on the completion			
	documentation of	f the observations by						
	supervisory staff were in the materials				thorough investigations in regator to client neglect and client to	iius		
	offered for review.				client abuse. Quality Assurance	ce		
				will be in-serviced on the				
	BDDS report of 6/28/13 indicated on				completion of investigations fo	r all		
	-	AM clients reported a			allegations of client to client			
		•			abuse and the implementation			
	` ′	ras sleeping while			corrective measures to preven			
	supervising clients. The 7/5/13 follow-up report indicated this allegation of sleeping was substantiated.				reoccurrence. Monitoring of Corrective Action: The			
					Residential Manager will make			
					random visits to the home duri			
					all shifts at least three times	9		
	BDDS report dated 10/25/13 indicated				weekly to ensure that staff is n	ot		
	•	ility reported staff #8 was			sleeping on the job and the			
		ob on 10/22/13 at 10:00			results of those visits will be se	ent		
		surance staff investigated			to the Program Manager each			
		•			week for review. If the			
	_	d it was substantiated on			Residential Manager finds any staff asleep while on duty, that			
	10/31/13.				staff member will be sent home			
	Interview with C	Quality Assurance staff #1			immediately pending QA			
		Quality Assurance staff #1			investigation and the residentia			
		:30 PM indicated there			manager will notify the prograr manager and the executive	II .		
		ited evidence of the house			director of the incident. The			
		orogram director doing			Program Manager will review			
	spot checks at ra	ndom times in an effort			incident reports and			
	to prevent staff f	from sleeping on the job.			investigations weekly with QA	to		
					ensure that all allegations have	Э		
	Interview with the	ne Administrator on			been thoroughly			
		20 PM indicated no			investigated. Completion date 12/08/13	:		
		e corrective measures			12/00/13			
		ations by supervisory						
	`							
	· · · · · · · · · · · · · · · · · · ·	onducted at the facility to						
	ensure staff were	e not sleeping on the job.						
	9-3-2(a)							
	y-3-2(α)							

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/31/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 15G442	A. BUILDING	00	11/08/2013
		100772	B. WING	ADDRESS CITY STATE ZID CORE	11/00/2010
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 402 EWING LN					
RES CARE COMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE COMPLETION THE APPROPRIATE DEFICIENCY) DATE COMPLETION DATE	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG		

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